Commonwealth of Kentucky
KY Medicaid

Provider Billing Instructions
For
Psychiatric Inpatient
Hospital Services
Provider Type – 02

Version 4.7

September 4, 2012

Document Change Log

Document Version	Date	Name	Comments
1.0	10/21/2005	HP Enterprise Services	Initial creation of DRAFT Billing Instructions for Psychiatric Inpatient Hospital Services Provider Type – 02
1.1	12/14/2005	HP Enterprise Services	Update revisions made by DMS
1.2	01/18/2006	HP Enterprise Services	Replaced Provider Rep list with most current list.
1.3	02/02/2006	Carolyn Stearman	Updated with revisions requested by DMS.
1.4	04/14/2006	Lize Deane	Updated with revisions requested by Commonwealth.
1.5	04/24/2006	Tammy Delk	Updated with revisions requested by Commonwealth.
1.6	04/27/2006	Lize Deane	Updated with revisions requested by Commonwealth.
1.7	09/18/2006	Ann Murray	Replaced Provider Representative table.
1.8	10/27/2006	Ron Chandler	Inserted new UB-04 claim form and descriptors.
1.9	11/14/2006	Lize Deane	Revisions made according to comment log.
2.0	11/15/2006	Lize Deane	Insert UB-04 with NPI.
2.1	12/22/2006	Ron Chandler	Updated UB04 with NPI form & UB92 form with data from Stayce Towles.
2.2	01/08/2007	Ann Murray	Updated with revisions requested by Stayce Towles.
2.3	01/30/2007	Ann Murray	Updated with revisions requested during walkthrough.
2.4	02/15/2007	Ann Murray	Updated Appendix C, KY Medicaid card and ICN.
2.5	02/21/2007	Ann Murray	Replaced Provider Rep table.

2.6	02/23/2007	Ann Murray	Revised according comment log Walkthrough. v1.8 – 2.6 are actually the same as revisions were made back-to-back and no publication would have been made
2.7	05/03/2007	Ann Murray	Updated and added claim forms and descriptors.
2.8	05/19/2008	Cathy Hill	Inserted revised provider rep list and presumptive eligibility per Stayce Towles.
2.9	05/20/2008	Cathy Hill	Made revisions requested by Stayce Towles v2.8 – 2.9 are actually the same as revisions were made back-to-back and no publication would have been made
3.0	07/23/2008	Ann Murray	Updated with changes for Medicare.
3.1	03/09/2009	Cathy Hill	Made changes from KyHealth Choices to KY Medicaid per Stayce Towles
3.2	03/11/2009	Cathy Hill	Revised contact info from First Health to Dept for Medicaid Services per Stayce Towles
3.3	03/19/2009	Cathy Hill	Added descriptions for Field 16, Discharge Hour, for the UB-04 form per Stayce Towles.
3.4	03/30/2009	Ann Murray	Made global revisions requested by DMS. v3.1 – 3.4 are actually the same as revisions were made back-to-back and no publication would have been made
3.5	09/08/2009	Ann Murray	Replaced Provider Rep list
3.6	10/21/2009	Ron Chandler	Replaced all instances of "EDS" with "HP Enterprise Services".
3.7	11/10/2009	Ann Murray	Replaced all instances of @eds.com with @hp.com. Removed HIPAA section. v3.6 – 3.7 are actually the same as revisions were made back-to-back and no publication would have been made
3.8	3/8/2010	Ron Chandler	Inserted new provider rep list.
3.9	11/18/2010	Patti George Ron Chandler	Revised per Patti George paper document with markup.

4.0	01/18/2011	Ann Murray	Updated global sections. v3.9 – 4.0 are actually the same as revisions were made back-to-back and no publication would have been made
4.1	07/12/2011	Patti George	Added Discharge Status 21 per CO 13326.
4.2	11/29/2011	Brenda Orberson Ann Murray	Updated 5010 changes. DMS approved 12/27/2011, Renee Thomas
4.3	02/08/2012	Stayce Towles Ann Murray	Updated provider rep listing. DMS Approved 02/14/2012, John Hoffman
4.4	02/22/2012	Brenda Orberson Ann Murray	Global updates made to remove all references to KenPAC and Lockin. DMS Approved 03/09/2012, John Hoffman
4.5	04/05/2012	Stayce Towles Ann Murray	Updated provider rep listing. DMS Approved 04/11/2012, John Hoffman
4.6	06/04/2012	Stayce Towles Ann Murray	Updated sections 6.1, 6.2.1, 6.3 and 6.4.1 based upon HP recommendation with DMS approval from Alisha Clark. DMS Approved 06/28/2012, Alisha Clark
4.7	08/30/2012	Stayce Towles Patti George	Replace Provider Inquiry form with new form approved by John Hoffman on 08/30/2012

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NUMBER	DESCRIPTION	PAGE

1   General

1.1   Introduction

These instructions are intended to assist persons filing claims for services provided to Kentucky Medicaid Members. Guidelines outlined pertain to the correct filing of claims and do not constitute a declaration of coverage or guarantee of payment.

Policy questions should be directed to the Department for Medicaid Services (DMS). Policies and regulations are outlined on the DMS website at:

http://chfs.ky.gov/dms/Regs.htm

Fee and rate schedules are available on the DMS website at:

http://chfs.ky.gov/dms/fee.htm

1.2   Member Eligibility

Members should apply for Medicaid eligibility through their local Department for Community Based Services (DCBS) office. Members with questions or concerns can contact Member Services at 1-800-635-2570, Monday through Friday. This office is closed on Holidays.

The primary identification for Medicaid-eligible members is the Kentucky Medicaid card. This is a permanent plastic card issued when the Member becomes eligible for Medicaid coverage. The name of the member and the member's Medicaid ID number are displayed on the card. The provider is responsible for checking identification and verifying eligibility before providing services.

NOTE: Payment cannot be made for services provided to ineligible members; and possession of a Member Identification card does not guarantee payment for all medical services.

1.2.1   Plastic Swipe KY Medicaid Card

KyHealth Choices

Kentucky
UNBRIDLED SPIRIT ™

CHILD CLAYTON
1234567890

Member Name

First, Middle Initial (if available), Last

10 DIGIT Member Identification Number

DO NOT THROW AWAY! This is your permanent medical card.

Card Holder: Show this card each time you receive any medical services.

Rules: 1. Use this card only for the person listed on the front of this card.
   2. Do not let anyone else use this card to get services.
   3. Do not give false information or hide information to get medical coverage.

If you break the rules, you can be prosecuted for fraud and have to pay money back.

If you need to replace this card, call your local DCBS office.
If you have questions about your coverage, call (800) 635-2570.
THIS CARD DOES NOT GUARANTEE ELIGIBILITY OR PAYMENT FOR SERVICES!

Provider: You are responsible for verifying the identity, eligibility, and co-pay status of the cardholder.
Eligibility information may be obtained at http://www.chfs.ky.gov/DMS or by calling (800) 807-1301.
Pharmacy information may be obtained by calling (800) 432-7005.

To report fraud call (800) 372-2970.

If found, please drop this card in any U.S. mailbox.
Return postage is guaranteed.

Commonwealth of Kentucky
Department for Community Based Services
275 East Main Street, 3W-A
Frankfort, KY 40621-0001

Magnetic Strip

Through a vendor of your choice, the magnetic strip can be swiped to obtain eligibility information.

Providers who wish to utilize the card's magnetic strip to access eligibility information may do so by contracting with one of several vendors.

1.2.2   Member Eligibility Categories

1.2.2.1   QMB and SLMB

Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB) are Members who qualify for both Medicare and Medicaid. In some cases, Medicaid may be limited. A QMB Member's card shows "QMB" or "QMB Only." QMB Members have Medicare and full Medicaid coverage, as well. QMB-only Members have Medicare, and Medicaid serves as a Medicare supplement only. A Member with SLMB does not have Medicaid coverage; Kentucky Medicaid pays a "buy-in" premium for SLMB Members to have Medicare, but offers no claims coverage.

1.2.2.2   Managed Care Partnership

Passport is a healthcare plan serving Kentucky Medicaid members who live in the following counties: Breckinridge, Bullitt, Carroll, Grayson, Hardin, Henry, Jefferson, Larue, Marion, Meade, Nelson, Oldham, Shelby, Spencer, Trimble, and Washington.

The other Managed Care Plans servicing Kentucky Medicaid members are WellCare of Kentucky, Kentucky Spirit Health Plan and CoventryCares of Kentucky. These plans are not county regional as Passport indicated above.

Medical benefits for persons whose care is overseen by an MCO are similar to those of Kentucky Medicaid, but billing procedures and coverage of some services may differ. Providers with Managed Care plan questions should contact: Passport Provider Services at 1-800-578-0775, WellCare of Kentucky at 1-877-389-9457, Kentucky Spirit Health Plan at 1-866-643-3153 and CoventryCares of Kentucky at 1-855-300-5528.

1.2.2.3   KCHIP

The Kentucky Children's Health Insurance Program (KCHIP) provides coverage to children through age 18 who have no insurance and whose household income meets program guidelines. Children with KCHIP III are eligible for all Medicaid-covered services except Non-Emergency Transportation and EPSDT Special Services. Regular KCHIP children are eligible for all Medicaid-covered services.

For more information, access the KCHIP website at http://kidshealth.ky.gov/en/kchip.

1.2.2.4   Presumptive Eligibility

Presumptive Eligibility (PE) is a program which offers pregnant women temporary medical coverage for prenatal care. A treating physician may issue an Identification Notice to a woman after pregnancy is confirmed. Presumptive Eligibility expires 90 days from the date the Identification Notice is issued, but coverage will not extend beyond three calendar months. This short-term program is only intended to allow a woman to have access to prenatal care while she is completing the application process for full Medicaid benefits.

1.2.2.4.1   Presumptive Eligibility Definitions

Presumptive Eligibility (PE) is designed to provide coverage for ambulatory prenatal services when the following services are provided by approved health care providers.

A. SERVICES COVERED UNDER PE

- Office visits to a Primary Care Provider (see list below) and/or Health Department

- Laboratory Services

- Diagnostic radiology services (including ultrasound)

- General dental services

- Emergency room services

- Transportation services (emergency and non-emergency)

- Prescription drugs (including prenatal vitamins)

B. DEFINITION OF PRIMARY CARE PROVIDER – Any health care provider who is enrolled as a KY Medicaid provider in one of the following programs:

- Physician/osteopaths practicing in the following medical specialties:

  - Family Practice

  - Obstetrics/Gynecology

  - General Practice

  - Pediatrics

  - Internal Medicine

- Physician Assistants

- Nurse Practitioners/ARNP's

- Nurse Midwives

- Rural Health Clinics

- Primary Care Centers

- Public Health Departments

C. SERVICES NOT COVERED UNDER PE

- Office visits or procedures performed by a specialist physician (those practicing in a specialty other than what is listed in Section B above), even if that visit/procedure is determined by a qualified PE primary care provider to be medically necessary

- Inpatient hospital services, including labor, delivery and newborn nursery services;

- Mental health/substance abuse services

- Any other service not specifically listed in Section A as being covered under PE

- Any services provided by a health care provider who is not recognized by the Department for Medicaid Services (DMS) as a participating provider

1.2.2.5   Breast & Cervical Cancer Treatment Program

Breast and Cervical Cancer Treatment Program (BCCTP) offers Medicaid coverage to women who have a confirmed cancerous or pre-cancerous condition of the breast or cervix. In order to

qualify, women must be screened and diagnosed with cancer by the Kentucky Women's Cancer Screening Program, be between the ages of 21 to 65, have no other insurance coverage, and not reside in a public institution. The length of coverage extends through active treatment for the breast or cervical cancer condition. Those members receiving Medicaid through the Breast and Cervical Cancer Program are entitled to full Medicaid services. Women who are eligible through PE or BCCTP do not receive a medical card for services. The enrolling provider will give a printed document that is to be used in place of a card.

1.2.3   Verification of Member Eligibility

This section covers:

- Methods for verifying eligibility;

- How to verify eligibility through an automated 800 number function;

- How to use other proofs to determine eligibility; and,

- What to do when a method of eligibility is not available.

1.2.3.1   Obtaining Eligibility and Benefit Information

Eligibility and benefit information is available to providers via the following:

- Voice Response Eligibility Verification (VREV) available 24 hours/7 days a week at 1-800-807-1301;

- KYHealth-Net at http://www.chfs.ky.gov/dms/kyhealth.htm

- The Department for Medicaid Services, Member Eligibility Branch at 1-800-635-2570, Monday through Friday, except Holidays.

1.2.3.1.1   Voice Response Eligibility Verification (VREV)

HP Enterprise Services maintains a Voice Response Eligibility Verification (VREV) system that provides member eligibility verification, as well as third party liability (TPL) information, Managed Care, PRO review, Card Issuance, Co-pay, provider check write, and claim status information.

The VREV system generally processes calls in the following sequence:

1. Greet the caller and prompt for mandatory provider ID.

2. Prompt the caller to select the type of inquiry desired (eligibility, check amount, claim status, and so on).

3. Prompt the caller for the dates of service (enter four digit year, for example, MMDDCCYY).

4. Respond by providing the appropriate information for the requested inquiry.

5. Prompt for another inquiry.

6. Conclude the call.

This system allows providers to take a shortcut to information. Users may key the appropriate responses (such as provider ID or Member number) as soon a each prompt begins. The number of inquiries is limited to five per call. The VREV spells the member name and

announces the dates of service. Check amount data is accessed through the VREV voice menu. The Provider's last three check amounts are available.

The telephone number (for use by touch-tone phones only) for the VREV is 1-800-807-1301. The VREV system cannot be accessed via rotary dial telephones.

1.2.3.1.2   KYHealth-Net Online Member Verification

KYHEALTH-NET ONLINE ACCESS CAN BE OBTAINED AT:

http://www.chfs.ky.gov/dms/kyhealth.htm

The KyHealth Net website is designed to provide real-time access to member information. A User Manual is available for downloading and is designed to assist providers in system navigation. Providers with suggestions, comments, or questions, should contact the HP Enterprise Services Electronic Claims Department at KY_EDI_Helpdesk@hp.com.

All Member information is subject to HIPAA privacy and security provisions, and it is the responsibility of the provider and the provider's system administrator to ensure all persons with access understand the appropriate use of this data. It is suggested that providers establish office guidelines defining appropriate and inappropriate uses of this data.

2   Electronic Data Interchange (EDI)

Electronic Data Interchange (EDI) is structured business-to-business communications using electronic media rather than paper.

2.1   How To Get Started

All Providers are encouraged to utilize EDI rather than paper claims submission. To become a business-to-business EDI Trading Partner or to obtain a list of Trading Partner vendors, contact the HP Enterprise Services Electronic Data Interchange Technical Support Help Desk at:

> HP Enterprise Services
> P.O. Box 2016
> Frankfort, KY 40602-2016
> 1-800-205-4696

Help Desk hours are between 7:00 a.m. and 6:00 p.m. Monday through Friday, except holidays.

2.2   Format and Testing

All EDI Trading Partners must test successfully with HP Enterprise Services and have Department for Medicaid Services (DMS) approved agreements to bill electronically before submitting production transactions. Contact the EDI Technical Support Help Desk at the phone number listed above for specific testing instructions and requirements.

2.3   ECS Help

Providers with questions regarding electronic claims submission may contact the EDI Help desk.

2.4   Companion Guides for Electronic Claims (837) Transactions

837 Companion Guides are available at:

http://www.kymmis.com/kymmis/Companion%20Guides/index.aspx

3   KyHealth Net

The KyHealth Net website allows providers to submit claims online via a secure, direct data entry function. Providers with internet access may utilize the user-friendly claims wizard to submit claims, in addition to checking eligibility and other helpful functions.

3.1   How To Get Started

All Providers are encouraged to utilize KyHealth Net rather than paper claims submission. To become a KyHealthNet user, contact our EDI helpdesk at 1-800-205-4696, or click the link below.

http://www.chfs.ky.gov/dms/kyhealth.htm

3.2   KyHealth Net Companion Guides.

Field-by-field instructions for KyHealth Net claims submission are available at:

http://www.kymmis.com/kymmis/Provider%20Relations/KYHealthNetManuals.aspx

4   General Billing Instructions for Paper Claim Forms

4.1   General Instructions

The Department for Medicaid Services is mandated by the Centers for Medicare and Medicaid Services (CMS) to use the appropriate form for the reimbursement of services. Claims may be submitted on paper or electronically.

4.2   Imaging

All paper claims are imaged, which means a digital photograph of the claim form is used during claims processing. This streamlines claims processing and provide efficient tools for claim resolution, inquiries, and attendant claim related matters.

By following the guidelines below, providers can ensure claims are processed as they intend:

- USE BLACK INK ONLY;

- Do not use glue;

- Do not use more than one staple per claim;

- Press hard to guarantee strong print density if claim is not typed or computer generated;

- Do not use white-out or shiny correction tape; and,

- Do not send attachments smaller than the accompanying claim form.

4.3   Optical Character Recognition

Optical Character Recognition (OCR) eliminates human intervention by sending the information on the claim directly to the processing system, bypassing data entry. OCR is used for computer generated or typed claims only. Information obtained mechanically during the imaging stage does not have to be manually typed, thus reducing claim processing time. Information on the claim must be contained within the fields using font 10 as the recommended font size in order for the text to be properly read by the scanner.

5   Additional Information and Forms

5.1   Claims with Dates of Service More than One Year Old

In accordance with federal regulations, claims must be received by Medicaid no more than 12 months from the date of service, or six months from the Medicare or other insurance payment date, whichever is later. "Received" is defined in 42 CFR 447.45 (d) (5) as "The date the agency received the claim as indicated by its date stamp on the claim."

Kentucky Medicaid includes the date received in the Internal Control Number (ICN). The ICN is a unique number assigned to each incoming claim and the claim's related documents during the data preparation process. Refer to Appendix A for more information about the ICN.

For claims more than 12 months old to be considered for processing, the provider must attach documentation showing timely receipt by DMS or HP Enterprise Services and documentation showing subsequent billing efforts, if any.

To process claims beyond the 12 month limit, you must attach to each claim form involved, a copy of a Claims in Process, Paid Claims, or Denied Claims section from the appropriate Remittance Statement no more than 12 months old, which verifies that the original claim was received within 12 months of the service date.

Additional documentation that may be attached to claims for processing for possible payment is:

- A screen print from KYHealth-Net verifying eligibility issuance date and eligibility dates must be attached behind the claim;

- A screen print from KYHealth-Net verifying filing within 12 months from date of service, such as the appropriate section of the Remittance Advice or from the Claims Inquiry Summary Page (accessed via the Main Menu's Claims Inquiry selection);

- A copy of the Medicare Explanation of Medicare Benefits received 12 months after service date but less than six months after the Medicare adjudication date; and,

- A copy of the commercial insurance carrier's Explanation of Benefits received 12 months after service date but less than six months after the commercial insurance carrier's adjudication date.

5.2   Retroactive Eligibility (Back-Dated) Card

Aged claims for Members whose eligibility for Medicaid is determined retroactively may be considered for payment if filed within one year from the eligilbility issuance date. Claim submission must be within 12 months of the issuance date. A copy of the KYHealth-Net card issuance screen must be attached behind the paper claim.

5.3   Unacceptable Documentation

Copies of previously submitted claim forms, providers' in-house records of claims submitted, or letters detailing filing dates are not acceptable documentation of timely billing. Attachments must prove the claim was received in a timely manner by HP Enterprise Services.

5.4 Third Party Coverage Information

5.4.1 Commercial Insurance Coverage (this does NOT include Medicare)

When a claim is received for a Member whose eligibility file indicates other health insurance is active and applicable for the dates of services, and no payment from other sources is entered on the Medicaid claim form, the claim is automatically denied unless documentation is attached.

5.4.2 Documentation That May Prevent A Claim from Being Denied for Other Coverage

The following forms of documentation prevent claims from being denied for other health insurance when attached to the claim.

1. Remittance statement from the insurance carrier that includes:

   - Member name;

   - Date(s) of service;

   - Billed information that matches the billed information on the claim submitted to Medicaid; and,

   - An indication of denial or that the billed amount was applied to the deductible.

NOTE: Rejections from insurance carriers stating "additional information necessary to process claim" is not acceptable.

2. Letter from the insurance carrier that includes:

   - Member name;

   - Date(s) of service(s);

   - Termination or effective date of coverage (if applicable);

   - Statement of benefits available (if applicable); and,

   - The letter must have a signature of an insurance representative, or be on the insurance company's letterhead.

3. Letter from a provider that states they have contacted the insurance company via telephone. The letter must include the following information:

   - Member name;

   - Date(s) of service;

   - Name of insurance carrier;

   - Name of and phone number of insurance representative spoken to or a notation indicating a voice automated response system was reached;

   - Termination or effective date of coverage; and,

   - Statement of benefits available (if applicable).

4. A copy of a prior remittance statement from an insurance company may be considered an acceptable form of documentation if it is:

- For the same Member;

- For the same or related service being billed on the claim; and,

- The date of service specified on the remittance advice is no more than six months prior to the claim's date of service.

NOTE: If the remittance statement does not provide a date of service, the denial may only be acceptable by HP Enterprise Services if the date of the remittance statement is no more than six months from the claim's date of service.

5. Letter from an employer that includes:

- Member name;

- Date of insurance or employee termination or effective date (if applicable); and,

- Employer letterhead or signature of company representative.

5.4.3 When there is no response within 120 days from the insurance carrier

When the other health insurance has not responded to a provider's billing within 120 days from the date of filing a claim, a provider may complete a TPL Lead Form. Write "no response in 120 days" on either the TPL Lead Form or the claim form, attach it to the claim and submit it to HP Enterprise Services. HP Enterprise Services overrides the other health insurance edits and forwards a copy of the TPL Lead form to the TPL Unit. A member of the TPL staff contacts the insurance carrier to see why they have not paid their portion of liability.

5.4.4 For Accident And Work Related Claims

For claims related to an accident or work related incident, the provider should pursue information relating to the event. If an employer, individual, or an insurance carrier is a liable party but the liability has not been determined, claims may be submitted to HP Enterprise Services with an attached letter containing any relevant information, such as, names of attorneys, other involved parties and/or the Member's employer to:

HP Enterprise Services
ATTN: TPL Unit
P.O. Box 2107
Frankfort, KY 40602-2107

5.4.4.1 TPL Lead Form

HP Enterprise Services

HP Enterprise Services
Attention: TPL Unit
P.O. Box 2107
Frankfort, KY 40602-2107

Third Party Liability Lead Form

Provider Name:_____   Provider #:_____

Member Name:_____   Member #:_____

Address:_____   Date of Birth:_____

From Date of Service:_____   To Date of Service:_____

Date of Admission:_____   Date of Discharge:_____

Insurance Carrier Name:_____

Address:_____

Policy Number:_____ Start Date:_____ End Date:_____

Date Claim Was Filed with Insurance Carrier:_____

Please check the one that applies:

_____   No Response in Over 120 Days

_____   Policy Termination Date: _____

_____   Other: Please explain in the space provided below

_____
_____
_____
_____

Contact Name:_____   Contact Telephone #:_____

Signature:_____   Date:_____

DMS Approved: January 10, 2011

5.5   Provider Inquiry Form

Provider Inquiry Forms may be used for any unique questions concerning claim status; paid or denied claims; and billing concerns. The mailing address for the Provider Inquiry Form is:

> HP Enterprise Services
> Provider Services
> P.O. Box 2100
> Frankfort, KY 40602-2100

Please keep the following points in mind when using this form:

- Send the completed form to HP Enterprise Services. A copy is returned with a response;

- When resubmitting a corrected claim, do not attach a Provider Inquiry Form;

- A toll free HP Enterprise Services number **1-800-807-1232** is available in lieu of using this form; and,

- To check claim status, call the HP Enterprise Services Voice Response on **1-800-807-1301**.

Provider Inquiry Form

HP Enterprise Services Corporation

Post Office Box 2100

Frankfort, KY 40602-2100

Did you know that electronic claim submission can reduce your processing time significantly? You can also check claim status, verify eligibility, download remittance advices, and many other functions. Go to www.kymmis.com or contact Billing Inquiry at 1-800-807-1232 for more information. You may also send an inquiry via e-mail at ky_provider_inquiry@hp.com

1. Provider Number	3. Member Name (first, last)	
2. Provider Name and Address	4. Medical Assistance Number	
	5. Billed Amount	6. Claim Service Date
7. Email	8.ICN (if applicable)	

. Provider's Message

10.
_____
Signature   Date

HP Enterprise Services Response: OFFICE USE ONLY

_____This claim has been resubmitted for possible payment.

_____This claim paid on _____in the amount of _____

_____This claim was denied on _____with EOB code_____

_____ Aged claim. Please see attached documentation concerning services submitted past the 12 month filing limit.

Other: _____

_____

Signature   Date

_____

5.6   Prior Authorization Information

- The prior authorization process does NOT verify anything except medical necessity. It does not verify eligibility nor age.

- The prior authorization letter does not guarantee payment. It only indicates that the service is approved based on medical necessity.

- If the individual does not become eligible for Kentucky Medicaid, loses Kentucky Medicaid eligibility, or ages out of the program eligibility, services will not be reimbursed despite having been deemed medically necessary.

- Prior Authorization should be requested prior to the provision of services except in cases of:

  - Retro-active Member eligibility

  - Retro-active provider number

- Providers should always completely review the Prior Authorization Letter prior to providing services or billing.

Access the KYHealth Net website to obtain blank Prior Authorization forms.

http://www.kymmis.com/kymmis/Provider%20Relations/PriorAuthorizationForms.aspx

Access to Electronic Prior Authorization request (EPA).

https://home.kymmis.com

5.7   Adjustments And Claim Credit Requests

An adjustment is a change to be made to a "PAID" claim. The mailing address for the Adjustment Request form is:

> HP Enterprise Services
> P.O. Box 2108
> Frankfort, KY 40602-2108
> Attn: Financial Services

Please keep the following points in mind when filing an adjustment request:

- Attach a copy of the corrected claim and the paid remittance advice page to the adjustment form. For a Medicaid/Medicare crossover, attach an EOMB (Explanation of Medicare Benefits) to the claim;

- Do not send refunds on claims for which an adjustment has been filed;

- Be specific. Explain exactly what is to be changed on the claim;

- Claims showing paid zero dollar amounts are considered paid claims by Medicaid. If the paid amount of zero is incorrect, the claim requires an adjustment; and,

- An adjustment is a change to a paid claim; a claim credit simply voids the claim entirely.

HP Enterprise Services

ADJUSTMENT AND CLAIM CREDIT REQUEST FORM

MAIL TO: HP Enterprise Services
                P.O. BOX 2108
                FRANKFORT, KY 40602-2108
                1-800-807-1232
                ATTN: FINANCIAL SERVICES

NOTE: **A CLAIM CREDIT VOIDS THE CLAIM ICN FROM THE SYSTEM -- A "NEW DAY" CLAIM MAY BE SUBMITTED, IF NECESSARY. THIS FORM WILL BE RETURNED TO YOU IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING ARE NOT PRESENT. PLEASE ATTACH A CORRECTED CLAIM AND REMITTANCE ADVICE TO ADJUST A CLAIM.**

CHECK APPROPRIATE BOX: CLAIM ADJUSTMENT ☐ CLAIM CREDIT ☐			1. Original Internal Control Number (ICN)	
2. Member Name			3. Member Medicaid Number	
4. Provider Name and Address	5. Provider	6. From Date of Service	7. To Date of Service	
	8. Original Billed Amount	9. Original Paid Amount	10. Remittance Advice Date	

11. Please specify **WHAT** is to be adjusted on the claim. You must explain in detail in order for an adjustment specialist to understand what needs to be accomplished by adjusting the claim.

_____

_____

12. Please specify the **REASON** for the adjustment or claim credit request.

_____

_____

_____

13. Signature _____   14. Date _____

DMS Approved: January 10, 2011

5.8   Cash Refund Documentation Form

The Cash Refund Documentation Form is used when refunding money to Medicaid. The mailing address for the Cash Refund Form is:

> HP Enterprise Services
> P.O. Box 2108
> Frankfort, KY 40602-2108
> Attn: Financial Services

Please keep the following points in mind when refunding:

- Attach the Cash Refund Documentation Form to a check made payable to the KY State Treasurer.

- Attach applicable documentation, such as a copy of the remittance advice showing the claim for which a refund is being issued.

- If refunding all claims on an RA, the check amount must match the total payment amount on the RA. If refunding multiple RAs, a separate check must be issued for each RA.

HP Enterprise Services

Mail To: *HP Enterprise Services*
P.O. Box 2108
Frankfort, KY 40602-2108
ATTN: Financial Services

CASH REFUND DOCUMENTATION

1. Check Number	2. Check Amount

3. Provider Name/ID /Address

4. Member Name

5. Member Number

6. From Date of Service	7. To Date of Service	8. RA Date

9. Internal Control Number (If several ICNs, attach RAs)

Research for Refund: (Check appropriate blank)

_____   **a.**   **Payment from other source - Check the category and list name** *(attach copy of EOB)*

      _____   **Health Insurance**
      _____   **Auto Insurance**
      _____   **Medicare Paid**
      _____   **Other**

_____   **b.**   **Billed in error**

_____   **c.**   **Duplicate payment (attach a copy of both RAs)**
               If RAs are paid to two different providers, specify to which provider ID the check is to be applied.

_____   **d.**   **Processing error OR overpayment (explain why)**

_____   **e.**   **Paid to wrong provider**

_____   **f.**   **Money has been requested - date of the letter**
               (attach a copy of letter requesting money)

_____   **g.**   **Other**

Contact Name _____   **Phone** _____

DMS Approved: January 10, 2011

5.9 Return To Provider Letter

Claims and attached documentation received by HP Enterprise Services are screened for required information (listed below). If the required information is not complete, the claim is returned to the provider with a "Return to Provider Letter" attached explaining why the claim is being returned.

A claim is returned before processing if the following information is missing:

- Provider ID;

- Member Identification number;

- Member first and last names; and,

- EOMB for Medicare/Medicaid crossover claims.

Other reasons for return may include:

- Illegible claim date of service or other pertinent data;

- Claim lines completed exceed the limit; and,

- Unable to image.

HP

RETURN TO PROVIDER LETTER

Date: _____ - _____ - _____

Dear Provider,
The attached claim is being returned for the following reason(s). These items require correction before the claim can be processed.

_____
01) ___ PROVIDER NUMBER – A valid 8-digit provider number must be on the claim form in the appropriate field.
    ___ Missing   ___ Not a valid provider number
_____
02) ___ PROVIDER SIGNATURE – All claims require an original signature in the provider signature block. The Provider signature cannot be stamped or typed on the claim.
    ___ Missing
    ___ Typed signature not valid
    ___ Stamped signature not valid.
_____
03) ___ Detail lines exceed the limit for claim type.
_____
04) ___ UNABLE TO IMAGE OR KEY – Claim form/EOMB must be legible. Highlighted forms cannot be accepted.
Please resubmit on a new form.
    ___ Print too light   ___ Print too dark   ___ Highlighted data fields   ___ Not legible   ___ Dark copy
_____
05) ___ Medicaid **does not** make payment when Medicare has paid the amount in full.
_____
06) ___ The Recipient's Medicaid (MAID) number is missing
_____
07) ___ Medicare EOMB does not match the claim
    ___Dates of Service   _____Recipient Number   ____Charges   ____ Balance due in Block 30
_____
08) __Other Reason-
_____

_____

_____ **Claims are being returned to you for correction for the reasons noted above.**

Helpful Hints When Billing for Services Provided to a Medicaid Recipient

- The Recipient's Medicaid number on the HCFA must be entered Field 9A
- The Recipient's Medicaid number on the UB92 must be entered in Block 60
- Medicare numbers **are not** valid Medicaid numbers
- Please refer to your billing manual if you have any concerns about billing the Medicaid program correctly.

Please make the necessary corrections and resubmit for processing. If you have any questions, please feel free to contact our Provider Relations Group, open Monday through Friday, 8:00 a.m. until 6:00 p.m. eastern standard/daylight savings time, at 1-800-807-1232.

If you are interested in billing Medicaid electronically please contact EDS at 1-800-205-4696 7:30 AM to 6PM Monday through Friday except holidays.

Initials of clerk _____

Provider Name _____

Provider Number _____

Reason Code _____

5.10 Provider Representative List

5.10.1 Phone Numbers and Assigned Counties

JACKIE RICHIE 502-209-3100 Extension 2021273 jackie.richie@hp.com			VICKY HICKS 502-209-3100 Extension 2021263 vicky.hicks@hp.com			PENNY GERMINARO 502-209-3100 Extension 2021281 penny.germinaro@hp.com
Assigned Counties			Assigned Counties			Assigned Counties
ADAIR	HARLAN	MCLEAN	ANDERSON	GRAYSON	MERCER	ALLEN
BALLARD	HENDERSON	MCCREARY	BATH	GREENUP	MONTGOMERY	BARREN
BELL	HICKMAN	METCALFE	BOURBON	HANCOCK	MORGAN	BOONE
BOYLE	HOPKINS	MONROE	BOYD	HARDIN	NELSON	CAMPBELL
BREATHITT	JACKSON	MUHLENBERG	BRACKEN	HARRISON	NICHOLAS	CARROLL
BULLITT	JEFFERSON	OLDHAM	BRECKINRIDGE	JESSAMINE	OHIO	EDMONSON
CALDWELL	KNOTT	OWSLEY	BUTLER	JOHNSON	POWELL	GALLATIN
CALLOWAY	KNOX	PERRY	CARTER	LAWRENCE	ROBERTSON	GRANT
CARLISLE	LARUE	PIKE	CLARK	LEE	ROWAN	HART
CASEY	LAUREL	PULASKI	DAVIESS	LEWIS	SHELBY	HENRY
CHRISTIAN	LESLIE	ROCKCASTLE	ELLIOTT	MADISON	SPENCER	KENTON
CLAY	LETCHER	RUSSELL	ESTILL	MAGOFFIN	WASHINGTON	OWEN
CLINTON	LINCOLN	TAYLOR	FAYETTE	MARTIN	WOLFE	PENDLETON
CRITTENDEN	LIVINGSTON	TODD	FLEMING	MASON	WOODFORD	SCOTT
CUMBERLAND	LOGAN	WAYNE	FRANKLIN	MEADE		SIMPSON
FLOYD	LYON	WHITLEY	GARRARD	MENIFEE		TRIMBLE
FULTON	MARION	TRIGG				WARREN
GRAVES	MARSHALL	UNION				
GREEN	MCCRACKEN	WEBSTER				

- **NOTE – Out-of-state providers contact the Representative who has the county closest bordering their state, unless noted above.**
- **Provider Relations 1-800-807-1232**

6 Completion of UB-04 Claim Form with NPI

Following are instructions for billing psychiatric inpatient hospital services on the UB-04 Billing Form. Only instructions for form locators required for HP Enterprise Services processing or Medicaid Program information are included. Instructions for form locators not used by HP Enterprise Services or Medicaid Program processing may be found in the UB-04 Training Manual. The UB-04 Training Manual and billing forms may be obtained from the address below:

> Kentucky Hospital Association
> P.O. Box 24163
> Louisville, KY 40224
> Telephone: 1-502-426-6220

Claims for mental hospital services provided to eligible Members must be submitted monthly to the Medicaid Program. A full calendar month's billing is required unless:

- The Member is admitted to the facility during the month;

- The Member is discharged or expires; and,

- The Member's authorization for benefit provisions is withdrawn by the PRO/UR Committee on the basis that further stay is not medically necessary.

Providers may not split-bill for a month's service (that is submitting bills more frequently than a full calendar month (1st through 15th; 16th through 31st)). All bills submitted must be calendar month pure.

A separate UB-04 billing form must be used for each Member.

The original UB-04 billing form must be submitted monthly to:

> HP Enterprise Services
> P.O. Box 2106
> Frankfort, KY 40602-2106

Courier delivery:

> HP Enterprise Services
> 656 Chamberlin Lane
> Frankfort, KY 40601

6.1 UB-04 Claim Form with NPI and Taxonomy

1 Provider Name		2		3a PAT. CNTL #	Patient Control Number		4 TYPE OF BILL
Street Address				b. MED. REC. #			111
City or Town	ST ZIP			5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7	
AC+Phone Number					010107 013107		

8 PATIENT NAME	a		9 PATIENT ADDRESS	a					c	d			e
b				b									

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22 23 24 25 26 27 28	29 ACDT STATE	30
01021900	01	010107	01	1		13	01	c1						

31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37
11 010107						09-29-2008

38		39 CODE VALUE CODES AMOUNT	40 CODE VALUE CODES AMOUNT	41 CODE VALUE CODES AMOUNT
	a	80 30		
	b			
	c			
	d			

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	120	ROOM CHARGES			30	30,000 00		1
2	250	PHARMACY			98	688 00		2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23	0001	*PAGE___ OF___*	CREATION DATE		TOTALS ➡	30,688.00		23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	Pay To NPI #	
A	Medicare				10 00		57	Pay To Taxonomy#	A
B	Medicaid/KyHealth Choices						OTHER	Facility Zip Code	B
C							PRV ID		C

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A	JANE DOE		4000000000			A
B						B
C						C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A	01234567			A
B				B
C				C

66 DX	234.5				G		H		68
					P		Q		

69 ADMIT DX	234.5	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI		73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75	76 ATTENDING	NPI	Attending NPI#	QUAL	
123.4 010207				LAST JONES		FIRST JAMES		
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		77 OPERATING	NPI		QUAL	
				LAST		FIRST		

80 REMARKS		81CC a		78 OTHER	NPI		QUAL	
		b		LAST		FIRST		
		c		79 OTHER	NPI		QUAL	
		d		LAST		FIRST		

UB-04 CMS-1450   APPROVED OMB NO.   THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC™ National Uniform Billing Committee
LIC9213257

6.2   Completion of UB-04 Claim Form with NPI and Taxonomy

6.2.1   Detailed Instructions

Included is a representative sample of codes and/or services that may be covered by KY Medicaid.

FORM LOCATOR NUMBER	FORM LOCATOR NAME AND DESCRIPTION		
1	**Provider Name, Address ad Telephone**		
	Enter the complete name, address, and telephone number (including area code) of the facility.		
3	**Patient Control Number**		
	Enter the patient control number. The first 14 digits (alpha/numeric) will appear on the remittance advice as the invoice number.		
4	**Type of Bill**		
	Enter the appropriate code to indicate the type of bill.		
	1st Digit	Enter zero.	
	2nd Digit (Type of Facility)	1 = Hospital	
	3rd Digit (Bill Classification)	1 = Inpatient (including Medicare Part A) 2 = Inpatient (Medicare Part B only) 3 = Outpatient 4 = Non-patient	
	4th Digit (Frequency)	0 = Non-payment 1 = Admit through discharge 2 = Interim, first claim 3 = Interim, continuing claim 4 = Interim, final claim	
6	**Statement Covers Period**		
	FROM: Enter the beginning date of the billing period covered by this invoice in numeric format (MMDDYY).		
	THROUGH: Enter the last date of the billing period covered by this invoice in numeric format (MMDDYY).		
	Do not include days prior to when the Member's KY Medicaid eligibility period began. The "FROM" date is the date of the admission if the Member was eligible for the KY Medicaid benefits upon admission. If the Member was not		

	eligible on the date of admission, the "FROM" date is the effective date of eligibility. The "THROUGH" date is the last covered day of the hospital stay.
10	**Date of Birth**
	Enter the member's date of birth.
12	**Admission Date**
	Enter the date on which the Member was admitted to the facility in numeric format (MMDDYY).
13	**Admission Hour**
	Enter the code for the time of admission to the facility. Admission hour is required for both inpatient and outpatient services.

	CODE STRUCTURE			
	CODE	**TIME A.M**	**CODE**	**TIME P.M.**
	00	12:00 - 12:59 midnight	12	12:00 - 12:59 noon
	01	01:00 - 01:59	13	01:00 - 01:59
	02	02:00 - 02:59	14	02:00 - 02:59
	03	03:00 - 03:59	15	03:00 - 03:59
	04	04:00 - 04:59	16	04:00 - 04:59
	05	05:00 - 05:59	17	05:00 - 05:59
	06	06:00 - 06:59	18	06:00 - 06:59
	07	07:00 - 07:59	19	07:00 - 07:59
	08	08:00 - 08:59	20	08:00 - 08:59
	09	09:00 - 09:59	21	09:00 - 09:59
	10	10:00 - 10:59	22	10:00 - 10:59
	11	11:00 - 11:59	23	11:00 - 11:59

14	**Admission Type**
	Enter the appropriate type of admission: 1 = Emergency

	2 = Urgent 3 = Elective 4 = Newborn	
16	**Discharge Hour**	
	Enter the code for the hour the member was discharged from the facility using the code structure described for Field 13 (above).	
17	**Patient Status Code**	
	Enter the appropriate two digit patient status code indicating the disposition of the patient as of the "through" date in Form Locator 6.	
	Status Codes Accepted by KY Medicaid.	
	01	Discharged to Home or Self Care (Routine Discharge)
	02	Discharged or Transferred to Acute Hospital
	03	Discharged or Transferred to Skilled Nursing Facility (SNF) or NF
	04	Discharged or Transferred to Intermediate Care Facility (ICF)
	05	Discharged or Transferred to Another Type of Institution
	06	Discharged or Transferred to Home Under Care of Organized Home Health Service Organization
	07	Left Against Medical Advice
	10	Discharged or Transferred to Mental Health Center or Mental Hospital
	20	Expired
	21	Discharge or Transfer to Court/Law Enforcement
	30	Still a Resident
18-28	**Condition Codes**	
	Peer Review Organization (PRO) Indicator	
	Enter the appropriate indicator, which describes the determination of the PRO/Utilization Review Committee.	
	C1 = Approved as Billed C2 = Automatic Approval as Billed Based on Focus Review	

	C3 = Partial Approval*	
	If the PRO authorized a portion of the Member's hospital stay, the approved date(s) must be shown in Form Locator 36, Occurrence Span. These dates should be the same as the dates of service in Form Locator 6.	
	The condition codes are also included in the UB-04 Training Manual. Information regarding the Peer Review Organization is located in the Reference Index.	
31-34	**Occurrence Codes and Dates**	
	Enter the appropriate code(s) and date(s) defining a significant event relating to this bill. Reference the UB-04 Training Manual for additional codes.	
	Accident Related Codes: 01 = Auto Accident 02 = No Fault Insurance Involved - Including Accident or Other 03 = Accident - Tort Liability 04 = Accident - Employment Related 05 = Other Accident - Not described by the other codes	
	Discharge Code and Date	
	Enter "42" and the actual discharge date when the "THROUGH" date in Form Locator 6 is not the actual discharge date and Form Locator 4 indicates "Final Bill."	
35-36	**Occurrence Span Code and Dates**	
	Enter occurrence span code "MO" and the first and last days approved by the PRO/UR when condition code C3 (partial approval) has been entered in Form Locators 18-28.	
37	**Medicare EOMB Date**	
	Enter the EOMB date from Medicare, if applicable.	
39-41	**Value Codes**	
	80 = Covered Days Enter the total number of covered days from Form Locator 6. Data entered in Form Locator 39 must agree with accommodation units in Form Locator 46. Covered days are not required for Medicare crossover claims for coinsurance days or life reserve days. 82 = Coinsurance Days Enter the number of coinsurance days billed to KY Medicaid during this	

	billing period.
	83 = Life Time Reserve Days
	Enter the Lifetime Reserve days the patient has elected to use for this billing period.
	A1 = Deductible Payer A
	Enter the amount as shown on the EOMB to be applied to the Member's deductible amount due.
	A2 = Coinsurance Payer A
	Enter the amount as shown on the EOMB to be applied toward Member's coinsurance amount due.
	B1 = Deductible Payer B
	Enter the amount as shown on the EOMB to be applied to the Member's deductible amount due.
	B2 = Coinsurance Payer B
	Enter the amount as shown on the EOMB to be applied toward Member's coinsurance amount due.
42	**Revenue Codes**
	Enter the three digit revenue code identifying specific accommodation and ancillary services. A list of revenue codes covered by KY Medicaid is located in Appendix B of this manual.
	It is extremely important that the ancillary services reported on the UB-04 billing form be submitted by using the correct Revenue Codes. All approved Revenue Codes are listed in Appendix B of this manual. Incorrect billing of ancillary services or failure to correct any remarks may ultimately affect the instate provider's prospective payment rate.
	NOTE: Total charge Revenue code 0001 must be the final entry in column 42, line 23.
	Total charge amount must be shown in column 47, line 23.
43	**Description**
	Enter the standard abbreviation assigned to each revenue code.
45	**Creation Date**
	Enter the invoice date or invoice creation date.
46	**Unit**
	Enter the quantitative measure of services provided per revenue code.

47	**Total Charges**
	Enter the total charges relating to each revenue code for the billing period. The detailed revenue code amounts must equal the entry "total charges. Claim total must be shown in field 47, line 23.
50	**Payer Identification**
	Enter the names of payer organizations from which the provider receives payment. For Medicaid, use KY Medicaid. All other liable payers, including Medicare, must be billed first.* * KY Medicaid is payer of last resort. **Note: If you are billing for a replacement policy to Medicare, Medicare needs to be indicated instead of the name of replacement policy.**
54	**Medicare Paid Amount**
	Enter the paid amount from Medicare, if applicable. Enter the amount paid, if any, be a private insurance.
56	**NPI**
	Enter the Pay To NPI number.
57	**Taxonomy**
	Enter the Pay To Taxonomy number.
57B	**Other**
	Enter the facilities zip code.
58	**Insured's Name**
	Enter the Member's name in Form Locators 58 A, B, and C that relates to the payer in Form Locators 50 A, B, and C. Enter the Member's name exactly as it appears on the Member Identification card in last name, first name, and middle initial format.
60	**Identification Number**
	Enter the Member Identification number in Form Locators 60 A, B, and C that relates to the Member's name in Form Locators 58 A, B, and C. Enter the 10 digit Member Identification number exactly as it appears on the Member Identification card.
63	**Prior Authorization Number**
	Enter the prior authorization number assigned by the PRO/UR designating that the treatment covered by the bill is authorized by the

	PRO/UR.
67	**Principal Diagnosis Code**
	Enter the ICD-9-CM Vol. 1 and 2 code describing the principal diagnosis.
67A-Q	**Other Diagnosis Code**
	Enter the ICD-9-CM Vol. 1 and 2 codes that co-exist at the time the service is provided.
69	**Admitting Diagnosis (Inpatient Only)**
	Enter the ICD-9-CM diagnosis code describing the admitting diagnosis.
76	**Attending Physician ID**
	Enter the Attending Physician NPI number.

6.3 UB-04 Claim Form with NPI Alone

NOTE: KY Medicaid advises providers to use this method when a single NPI corresponds to a single KY Medicaid provider ID.

1 Provider Name		2		3a PAT. CNTL #	Patient Control Number		4 TYPE OF BILL
Street Address				b. MED. REC. #			111
City or Town	ST ZIP			5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7	
AC+Phone Number					010107 013107		

8 PATIENT NAME	a		9 PATIENT ADDRESS	a				
b			b			c	d	e

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22 23 24 25 26 27 28	29 ACDT STATE	30
01021900		010107	01	1		13	01	c1						

31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 CODE	OCCURRENCE SPAN FROM THROUGH	36 CODE	OCCURRENCE SPAN FROM THROUGH	37
11 010107								09-29-2008

38		39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
	a	80	30				
	b						
	c						
	d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 120	ROOM CHARGES			30	30,000 00		1
2 250	PHARMACY			98	688 00		2
3							3
23 0001	*PAGE____ OF____*	*CREATION DATE*		**TOTALS** ➡	30,688.00		23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	Pay To NPI #
A Medicare				30 00		57	A
B Medicaid/KyHealth Choices						OTHER	B
C						PRV ID	C

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A JANE DOE		4000000000			A
B					B
C					C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A 01234567			A
B			B
C			C

66 DX	234.5					68	

69 ADMIT DX	234.5	70 PATIENT REASON DX a b c	71 PPS CODE	72 ECI	73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75	76 ATTENDING NPI Attending NPI#	QUAL
123.4 010207				LAST JONES	FIRST JAMES
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		77 OPERATING NPI	
				LAST	FIRST

80 REMARKS	81CC a	78 OTHER NPI	QUAL
	b	LAST	FIRST
	c	79 OTHER NPI	QUAL
	d	LAST	FIRST

UB-04 CMS-1450   APPROVED OMB NO.   THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC National Uniform Billing Committee
LIC9213257

6.4 Completion of UB-04 Claim Form with NPI Alone

6.4.1 Detailed Instructions

Included is a representative sample of codes and/or services that may be covered by KY Medicaid.

NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.

FORM LOCATOR NUMBER	FORM LOCATOR NAME AND DESCRIPTION	
1	**Provider Name, Address ad Telephone**	
	Enter the complete name, address, and telephone number (including area code) of the facility.	
3	**Patient Control Number**	
	Enter the patient control number. The first 14 digits (alpha/numeric) will appear on the remittance advice as the invoice number.	
4	**Type of Bill**	
	Enter the appropriate code to indicate the type of bill.	
	1st Digit	Enter zero.
	2nd Digit (Type of Facility)	1 = Hospital
	3rd Digit (Bill Classification)	1 = Inpatient (including Medicare Part A) 2 = Inpatient (Medicare Part B only) 3 = Outpatient 4 = Non-patient
	4th Digit (Frequency)	0 = Non-payment 1 = Admit through discharge 2 = Interim, first claim 3 = Interim, continuing claim 4 = Interim, final claim
6	**Statement Covers Period**	
	FROM: Enter the beginning date of the billing period covered by this invoice in numeric format (MMDDYY).	
	THROUGH: Enter the last date of the billing period covered by this invoice in numeric format (MMDDYY).	
	Do not include days prior to when the Member's KY Medicaid eligibility	

	period began.
	The "FROM" date is the date of the admission if the Member was eligible for the KY Medicaid benefits upon admission. If the Member was not eligible on the date of admission, the "FROM" date is the effective date of eligibility.
	The "THROUGH" date is the last covered day of the hospital stay.
10	**Date of Birth**
	Enter the member's date of birth.
12	**Admission Date**
	Enter the date on which the Member was admitted to the facility in numeric format (MMDDYY).
13	**Admission Hour**
	Enter the code for the time of admission to the facility. Admission hour is required for both inpatient and outpatient services.
	CODE STRUCTURE

		CODE	TIME A.M	CODE	TIME P.M.
		00	12:00 - 12:59 midnight	12	12:00 - 12:59 noon
		01	01:00 - 01:59	13	01:00 - 01:59
		02	02:00 - 02:59	14	02:00 - 02:59
		03	03:00 - 03:59	15	03:00 - 03:59
		04	04:00 - 04:59	16	04:00 - 04:59
		05	05:00 - 05:59	17	05:00 - 05:59
		06	06:00 - 06:59	18	06:00 - 06:59
		07	07:00 - 07:59	19	07:00 - 07:59
		08	08:00 - 08:59	20	08:00 - 08:59
		09	09:00 - 09:59	21	09:00 - 09:59
		10	10:00 - 10:59	22	10:00 - 10:59
		11	11:00 - 11:59	23	11:00 - 11:59
14	**Admission Type**				

<table>
<tr><td></td><td colspan="2">Enter the appropriate type of admission:

1 = Emergency
2 = Urgent
3 = Elective
4 = Newborn</td></tr>
<tr><td>**16**</td><td colspan="2">**Discharge Hour**</td></tr>
<tr><td></td><td colspan="2">Enter the code for the hour the member was discharged from the facility using the code structure described for Field 13 (above).</td></tr>
<tr><td>**17**</td><td colspan="2">**Patient Status Code**</td></tr>
<tr><td></td><td colspan="2">Enter the appropriate two digit patient status code indicating the disposition of the patient as of the "through" date in Form Locator 6.</td></tr>
<tr><td></td><td colspan="2">**Status Codes Accepted by KY Medicaid.**</td></tr>
<tr><td></td><td>01</td><td>Discharged to Home or Self Care (Routine Discharge)</td></tr>
<tr><td></td><td>02</td><td>Discharged or Transferred to Acute Hospital</td></tr>
<tr><td></td><td>03</td><td>Discharged or Transferred to Skilled Nursing Facility (SNF) or NF</td></tr>
<tr><td></td><td>04</td><td>Discharged or Transferred to Intermediate Care Facility (ICF)</td></tr>
<tr><td></td><td>05</td><td>Discharged or Transferred to Another Type of Institution</td></tr>
<tr><td></td><td>06</td><td>Discharged or Transferred to Home Under Care of Organized Home Health Service Organization</td></tr>
<tr><td></td><td>07</td><td>Left Against Medical Advice</td></tr>
<tr><td></td><td>10</td><td>Discharged or Transferred to Mental Health Center or Mental Hospital</td></tr>
<tr><td></td><td>20</td><td>Expired</td></tr>
<tr><td></td><td>21</td><td>Discharge or Transfer to Court/Law Enforcement</td></tr>
<tr><td></td><td>30</td><td>Still a Resident</td></tr>
<tr><td>**18-28**</td><td colspan="2">**Condition Codes**</td></tr>
<tr><td></td><td colspan="2">Peer Review Organization (PRO) Indicator</td></tr>
<tr><td></td><td colspan="2">Enter the appropriate indicator, which describes the determination of the</td></tr>
</table>

	PRO/Utilization Review Committee.
	C1 = Approved as Billed C2 = Automatic Approval as Billed Based on Focus Review C3 = Partial Approval*
	If the PRO authorized a portion of the Member's hospital stay, the approved date(s) must be shown in Form Locator 36, Occurrence Span. These dates should be the same as the dates of service in Form Locator 6.
	The condition codes are also included in the UB-04 Training Manual. Information regarding the Peer Review Organization is located in the Reference Index.
31-34	**Occurrence Codes and Dates**
	Enter the appropriate code(s) and date(s) defining a significant event relating to this bill. Reference the UB-04 Training Manual for additional codes.
	Accident Related Codes: 01 = Auto Accident 02 = No Fault Insurance Involved - Including Accident or Other 03 = Accident - Tort Liability 04 = Accident - Employment Related 05 = Other Accident - Not described by the other codes
	Discharge Code and Date
	Enter "42" and the actual discharge date when the "THROUGH" date in Form Locator 6 is not the actual discharge date and Form Locator 4 indicates "Final Bill."
35-36	**Occurrence Span Code and Dates**
	Enter occurrence span code "MO" and the first and last days approved by the PRO/UR when condition code C3 (partial approval) has been entered in Form Locators 18-28.
37	**Medicare EOMB Date**
	Enter the EOMB date from Medicare, if applicable.
39-41	**Value Codes**
	80 = Covered Days Enter the total number of covered days from Form Locator 6. Data entered in Form Locator 39 must agree with accommodation units in Form Locator 46. Covered days are not required for Medicare crossover

	claims for coinsurance days or life reserve days.
	82 = Coinsurance Days
	Enter the number of coinsurance days billed to KY Medicaid during this billing period.
	83 = Life Time Reserve Days
	Enter the Lifetime Reserve days the patient has elected to use for this billing period.
	A1 = Deductible Payer A
	Enter the amount as shown on the EOMB to be applied to the Member's deductible amount due.
	A2 = Coinsurance Payer A
	Enter the amount as shown on the EOMB to be applied toward Member's coinsurance amount due.
	B1 = Deductible Payer B
	Enter the amount as shown on the EOMB to be applied to the Member's deductible amount due.
	B2 = Coinsurance Payer B
	Enter the amount as shown on the EOMB to be applied toward Member's coinsurance amount due.
42	**Revenue Codes**
	Enter the three digit revenue code identifying specific accommodation and ancillary services. A list of revenue codes covered by KY Medicaid is located in Appendix B of this manual.
	It is extremely important that the ancillary services reported on the UB-04 billing form be submitted by using the correct Revenue Codes. All approved Revenue Codes are listed in Appendix B of this manual. Incorrect billing of ancillary services or failure to correct any remarks may ultimately affect the instate provider's prospective payment rate.
	NOTE: Total charge Revenue code 0001 must be the final entry in column 42, line 23.
	Total charge amount must be shown in column 47, line 23.
43	**Description**
	Enter the standard abbreviation assigned to each revenue code.
45	**Creation Date**
	Enter the invoice date or invoice creation date.

46	Unit
	Enter the quantitative measure of services provided per revenue code.
47	Total Charges
	Enter the total charges relating to each revenue code for the billing period. The detailed revenue code amounts must equal the entry "total charges.

Claim total must be shown in field 47, line 23. |
| 50 | Payer Identification |
| | Enter the names of payer organizations from which the provider receives payment. For Medicaid, use KY Medicaid. All other liable payers, including Medicare, must be billed first.*

* KY Medicaid is payer of last resort.

Note: If you are billing for a replacement policy to Medicare, Medicare needs to be indicated instead of the name of replacement policy. |
54	Medicare Paid Amount
	Enter the paid amount from Medicare, if applicable. Enter the amount paid, if any, be a private insurance.
56	NPI
	Enter the Pay To NPI number.

NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim. |
58	Insured's Name
	Enter the Member's name in Form Locators 58 A, B, and C that relates to the payer in Form Locators 50 A, B, and C. Enter the Member's name exactly as it appears on the Member Identification card in last name, first name, and middle initial format.
60	Identification Number
	Enter the Member Identification number in Form Locators 60 A, B, and C that relates to the Member's name in Form Locators 58 A, B, and C. Enter the 10 digit Member Identification number exactly as it appears on the Member Identification card.
63	Prior Authorization Number
	Enter the prior authorization number assigned by the PRO/UR designating that the treatment covered by the bill is authorized by the

	PRO/UR.
67	**Principal Diagnosis Code**
	Enter the ICD-9-CM Vol. 1 and 2 code describing the principal diagnosis.
67A-Q	**Other Diagnosis Code**
	Enter the ICD-9-CM Vol. 1 and 2 codes that co-exist at the time the service is provided.
69	**Admitting Diagnosis (Inpatient Only)**
	Enter the ICD-9-CM diagnosis code describing the admitting diagnosis.
76	**Attending Physician ID**
	Enter the Attending Physician NPI number.

6.5   Duplicate or Inappropriate Payments

Any duplicate or inappropriate payment by the KY Medicaid Program, whether due to erroneous billing or payment system faults, shall be refunded to the KY Medicaid Program. Refund checks shall be made payable to "KY State Treasurer" and sent immediately to:

HP Enterprise Services P.O. Box 2108

Frankfort, KY 40602-2108

ATTN: Financial Services Unit

Failure to refund a duplicate or inappropriate payment could be interpreted as fraud or abuse and prosecuted.

7 MAP 24 Memorandum To Local Community Based Services

The MAP-24 is used to report the discharge or death of any Title XIX resident to the local department for Community Based Services office. This flow of information is essential to timely payment to the facility and efficient records for the Community Based Services office. Complete all entries as appropriate and mail to the local Department for Community Based Services office within ten days of discharge or death.

CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, 40621-0001

DEPARTMENT FOR MEDICAID SERVICES
"An Equal Opportunity Employer M/F/D"

_____
(Date)

MEMORANDUM

TO: Local Office
Department for Community Based Services
Cabinet for Families & Children

FROM: _____ Provider #: _____
(Facility/Waiver Agency)

SUBJECT: _____
(Recipient Name)   (Social Security/Medicaid Number)

_____
(Previous Address)

_____
(Responsible Relative's Name & Address)

This is to notify you that the above-referenced recipient

☐ Was admitted to this facility/waiver agency _____
(Date)
Is in Title _____ Payment Status, and was placed in a
(XVIII or XIX)

☐ NF bed   ☐ ICF/MR/DD bed   ☐ MH bed   ☐ EPSDT Bed

☐ Home & Community Based Waiver Service   ☐ SCL Waiver Service and/or

☐ Was discharged from this facility/waiver agency on _____
(Date)
And went to _____,
(Home Address/Name & Address of New Facility/Waiver Agency)
And/or expired on _____.
(Date)

☐ Was re-instated to Home & Community Based or SCL waiver services within 60 days of
the

NF admission. _____
(Date Re-instated)

For Home & Community Based waiver Clients only – last date service was provided _____.
(Date)

_____   (Signature)

MAP-24 (Rev. 02/2001)

8   Medicare Deductibles and Coinsurance

Billing for Medicare Part A deductible or coinsurance days, Medicare Part B deductible or coinsurance, and Title XIX services must be on separate claim forms. If the Member is covered by Medicare Part A, Medicare Part B, and Medicaid, three separate claims must be submitted for payment for the three types of benefits.

Medicaid PRO certification is not required on Medicare deductible and coinsurance claims as certification is determined using Medicare guidelines. If all Medicare benefits are exhausted and Title XIX days are being billed, Medicaid PRO certification for Medicaid days is required.

If a claim does not appear on your Medicaid remittance advice within 30 days of the Medicare adjudication date, a paper UB-04 should be submitted to the Medicaid Program.

9 Appendix A

9.1 Revenue Codes

Following is a list of the revenue codes that are accepted by the Medicaid Program when billing for inpatient services on the UB-04 billing form.

INPATIENT REVENUE CODES	DESCRIPTION
114	Private Bed Psychiatric
124	Two Bed Psychiatric
134	Three Bed Psychiatric
154	Ward Psychiatric
250	Pharmacy
270	Medical / Surgical Supplies
300	Laboratory
320	Radiology Diagnostic
330	Radiology Therapeutic
350	CT Scan
351	CT Head Scan
352	CT Body Scan
610	MRI
611	MRI Brain
612	MRI Spinal Cord
730	EKG / ECG
740	EEG
9011	Electroshock Treatment
960	Pro Fee (to be used only for hospital-based physicians other than psychiatrists

961	Psychiatric Pro Fee
971	Lab Pro fee
972	Radiology – (Diag) Pro Fee
973	Radiology – (Ther) Pro Fee
974	Radiology Nuclear Medicine
985	EKG ECG Pro Fee
986	EEG Pro Fee
001	Total Charges

Note - When billing professional component services for electro shock treatment, use Revenue Code 960.

PROFESSIONAL COMPONENT REVENUE CODES

The following revenue codes (column A) are professional component revenue codes and cannot be billed unless they are billed in conjunction with the revenue codes in column B.

A		B
971	Must be in conjunction with	300
972	Must be in conjunction with either	320, 350, 351, 352, 610, 611 or 612
973	Must be in conjunction with	330
974	Must be in conjunction with either	350, 351 or 352
985	Must be in conjunction with	730
986	Must be in conjunction with	740

REVENUE CODES FOR ALL INCLUSIVE ANCILLARY BILLING

Following is a list of revenue codes accepted by the Medicaid Program on the UB-04 billing form in Form Locator 42 when revenue code 240, All Inclusive Ancillary is used.

114	Private Bed Psychiatric	PSTAY / PVT
124	Two Bed Psychiatric	PSTAY / 2BED
134	Three Bed Psychiatric	PSTAY / 3BED
154	Ward Psychiatric	PSTAY / WARD
240	All Inclusive Ancillary	ALL INCL ANCIL
960	Pro Fee (to be used only for hospital-based physicians other than psychiatrists)	PRO FEE
961	Psychiatric Pro Fee	PRO FEE / PSTAY
001	Total Charges	

10 Appendix B

10.1 Internal Control Number (ICN)

An Internal Control Number (ICN) is assigned by HP Enterprise Services to each claim. During the imaging process a unique control number is assigned to each individual claim for identification, efficient retrieval, and tracking. The ICN consists of 13 digits and contains the following information:

$$11 - 10 - 032 - 123456$$
$$1 \quad 2 \quad 3 \quad 4$$

1. Region

10	PAPER CLAIMS WITH NO ATTACHMENTS
11	PAPER CLAIMS WITH ATTACHMENTS
20	ELECTRONIC CLAIMS WITH NO ATTACHMENTS
21	ELECTRONIC CLAIMS WITH ATTACHMENTS
22	INTERNET CLAIMS WITH NO ATTACHMENTS
40	CLAIMS CONVERTED FROM OLD MMIS
45	ADJUSTMENTS CONVERTED FROM OLD MMIS
50	ADJUSTMENTS - NON-CHECK RELATED
51	ADJUSTMENTS - CHECK RELATED
52	MASS ADJUSTMENTS - NON-CHECK RELATED
53	MASS ADJUSTMENTS - CHECK RELATED
54	MASS ADJUSTMENTS - VOID TRANSACTION
55	MASS ADJUSTMENTS - PROVIDER RATES
56	ADJUSTMENTS - VOID NON-CHECK RELATED
57	ADJUSTMENTS - VOID CHECK RELATED

2. Year of Receipt

3. Julian Date of Receipt (The Julian calendar numbers the days of the year 1-365. For example, 001 is January 1 and 032 (shown above) is February 1.

4. Batch Sequence Used Internally

11 Appendix C

11.1 Remittance Advice

This section is a step-by-step guide to reading a Kentucky Medicaid Remittance Advice (RA). The following sections describe major categories related to processing/adjudicating claims. To enhance this document's usability, detailed descriptions of the fields on each page are included, reading the data from left to right, top to bottom.

11.1.1 Examples Of Pages In Remittance Advice

There are several types of pages in a Remittance Advice, including separate page types for each type of claim; however, if a provider does not have activity in that particular category, those pages are not included.

Following are examples of pages which may appear in a Remittance Advice:

FIELD	DESCRIPTION
Returned Claims	This section lists all claims that have been returned to the provider with an RTP letter. The RTP letter explains why the claim is being returned. These claims are returned because they are missing information required for processing.
Paid Claims	This section lists all claims paid in the cycle.
Denied Claims	This section lists all claims that denied in the cycle.
Claims In Process	This section lists all claims that have been suspended as of the current cycle. The provider should maintain this page and compare with future Remittance Advices until all the claims listed have appeared on the PAID CLAIMS page or the DENIED CLAIMS page. Until that time, the provider need not resubmit the claims listed in this section.
Adjusted Claims	This section lists all claims that have been submitted and processed for adjustment or claim credit transactions.
Mass Adjusted Claims	This section lists all claims that have been mass adjusted at the request of the Department for Medicaid Services (DMS).
Financial Transactions	This section lists financial transactions with activity during the week of the payment cycle.
	NOTE: It is imperative the provider maintains any A/R page with an outstanding balance.

Summary	This section details all categories contained in the Remittance Advice for the current cycle, month to date, and year to date. Explanation of Benefit (EOB) codes listed throughout the Remittance Advice is defined in this section.
EOB Code Descriptions	Any Explanation of Benefit Codes (EOB) which appear in the RA are defined in this section.

NOTE: For the purposes of reconciliation of claims payments and claims resubmission of denied claims, it is highly recommended that all remittance advices be kept for at least one year.

11.2 Title

The header information that follows is contained on every page of the Remittance Advice.

```
REPORT:   CRA-XBPD-R              COMMONWEALTH OF KENTUCKY (M1)           DATE:  01/25/2007
   RA#:      9999999           MEDICAID MANAGEMENT INFORMATION SYSTEM      PAGE:        2
                                   PROVIDER REMITTANCE ADVICE
```

FIELD	DESCRIPTION
DATE	The date the Remittance Advice was printed.
RA NUMBER	A system generated number for the Remittance Advice.
PAGE	The number of the page within each Remittance Advice.
CLAIM TYPE	The type of claims listed on the Remittance Advice.
PROVIDER NAME	The name of the provider that billed. (The type of provider is listed directly below the name of provider.)
PAYEE ID	The eight-digit Medicaid assigned provider ID of the billing provider.
NPI ID	The NPI number of the billing provider.

The category (type of page) begins each section and is centered (for example, *PAID CLAIMS*). All claims contained in each Remittance Advice are listed in numerical order of the prescription number.

11.3 Banner Page

All Remittance Advices have a "banner page" as the first page. The "banner page" contains provider specific information regarding upcoming meetings and workshops, "top ten" billing errors, policy updates, billing changes etc. Please pay close attention to this page.

```
REPORT:   CRA-BANN-R                    COMMONWEALTH OF KENTUCKY (M1)                          DATE: 01/23/2007
RA#:      9999999                  MEDICAID MANAGEMENT INFORMATION SYSTEM                      PAGE:         1
                                         PROVIDER REMITTANCE ADVICE
                                         PROVIDER BANNER MESSAGES


PROVIDER                                                                    PAYEE ID            99999999
555 ANY STREET                                                              NPI ID              99999999
CITY, KY 55555-0000                                                         CHECK/EFT NUMBER   999999999
                                                                            ISSUE DATE         01/26/2007



Commonwealth of Kentucky
```

```
REPORT:   CRA-IPPD-R                    COMMONWEALTH OF KENTUCKY (M1)              DATE: 01/30/2007
RA#:      9999999                    MEDICAID MANAGEMENT INFORMATION SYSTEM       PAGE:        2
                                           PROVIDER REMITTANCE ADVICE
                                               UB CLAIMS PAID

PROVIDER                                                                   PAYEE ID              99999999
5555 ANY STREET                                                            NPI ID
CITY, KY 55555-5555                                                        CHECK/EFT NUMBER      999999999
                                                                           ISSUE DATE            02/02/2007

--ICN--          ATTENDING PROV.    SERVICE DATES  DAYS  ADMIT    BILLED AMT    ALLOWED AMT    SPENDDOWN     TPL AMT      PAID AMT
PAT.ACCT NUM.                       FROM    THRU          DATE                                 COPAY AMT

MEMBER NAME: JANE DOE                        MEMBER NO.: MBRID99999
ICN9999999999        NPI9999999     030806 031006  2    030806     6,307.35          0.00        0.00         0.00      3,488.25
PATACCT 99999999999                                                                              0.00

HEADER EOBS:  9932 00A2

REV CD HCPCS/RATE SRV DATE LVL CARE    UNITS      BILLED AMT  ALLOWED AMT    DETAIL EOBS
 120              030806    DEF          2.00       1,700.00        0.00     2527 0062 0883 0018
 250              030806    DEF         48.00         653.90        0.00     9932 0018
 258              030806    DEF          7.00         275.30        0.00     9932 0018
 270              030806    DEF         67.00         386.15        0.00     9932 0018
 300              030806    DEF         12.00         292.00        0.00     9932 0018
 310              030806    DEF          3.00         177.00        0.00     9932 0018
 360              030806    DEF          1.00       2,148.00        0.00     9932 0018
 370              030806    DEF          1.00         299.00        0.00     9932 0018
 710              030806    DEF          1.00         376.00        0.00     9932 0018


MEMBER NAME: JANE DOE                        MEMBER NO.: 9999999999
9999999999999    9999999999         030806 031006  2    030806     6,307.35          0.00        0.00         0.00      3,488.25
  99999999999                                                                                    0.00

HEADER EOBS:  9932 0018

REV CD HCPCS/RATE SRV DATE LVL CARE    UNITS      BILLED AMT  ALLOWED AMT    DETAIL EOBS

 120              030806    DEF          2.00       1,700.00        0.00     9932 0018 0275 0015
 250              030806    DEF         48.00         653.90        0.00     9932 0015 0883 00
 258              030806    DEF          7.00         275.30        0.00     9932 0018
 270              030806    DEF         67.00         386.15        0.00     9932 0018
 300              030806    DEF         12.00         292.00        0.00     9932 0018
 310              030806    DEF          3.00         177.00        0.00     9932 0018
 360              030806    DEF          1.00       2,148.00        0.00     9932 0018
 370              030806    DEF          1.00         299.00        0.00     9932 0018
 710              030806    DEF          1.00         376.00        0.00     9932 0018

                  TOTAL UB CLAIMS PAID:                            12,614.70        0.00        0.00         0.00      6,976.50
```

11.4 Paid Claims Page

FIELD	DESCRIPTION
PATIENT ACCOUNT	The 14-digit alpha/numeric Patient Account Number from Form Locator 3.
MEMBER NAME	The Member's last name and first initial.
MEMBER NUMBER	The Member's ten-digit Identification number as it appears on the Member's Identification card.
ICN	The 12-digit unique system generated identification number assigned to each claim by HP Enterprise Services.
ATTENDING PROVIDER	The member's attending provider.
CLAIM SERVICE DATES FROM – THRU	The date or dates the service was provided in month, day, and year numeric format.
DAYS	The number of days billed.
ADMIT DATE	The admit date of the member.
BILLED AMOUNT	The usual and customary charge for services provided for the Member.
ALLOWED AMOUNT	The allowed amount for Medicaid
SPENDDOWN COPAY AMOUNT	The amount collected from the member.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
PAID AMOUNT	The total dollar amount reimbursed by Medicaid for the claim listed.
EOB	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
CLAIMS PAID ON THIS RA	The total number of paid claims on the Remittance Advice.
TOTAL BILLED	The total dollar amount billed by the provider for all claims listed on the PAID CLAIMS page of the Remittance Advice (only on final page of section).
TOTAL PAID	The total dollar amount paid by Medicaid for all claims listed on the PAID CLAIMS page of the Remittance Advice (only on final page of section).

```
REPORT:   CRA-IPDN-R                 COMMONWEALTH OF KENTUCKY (M1)                        DATE: 01/25/2007
RA#:      9999999              MEDICAID MANAGEMENT INFORMATION SYSTEM                     PAGE:      11
                                     PROVIDER REMITTANCE ADVICE
                                        UB CLAIMS DENIED


PROVIDER                                                              PAYEE ID            99999999
5555 ANY STREET                                                      NPI ID              99999999
SUITE 555                                                            CHECK/EFT NUMBER    999999999
CITY, KY 55555-0000                                                 ISSUE DATE          01/26/2007

   --ICN--        ATTENDING PROV.      SERVICE DATES   DAYS   ADMIT        BILLED        TPL       SPENDDOWN
 PATIENT ACCT.    NUM.                 FROM    THRU           DATE         AMOUNT        AMOUNT    AMOUNT

MEMBER NAME: JANE DOE                          MEMBER NO.: MBRID99999
ICN9999999999    NPI9999999           021706 022106   4    021706       10,212.66        0.00          0.00
PATACCT9999

HEADER EOBS:  2660 0092

REV CD HCPCS/RATE SRV DATE LVL CARE    UNITS     BILLED AMT   DETAIL EOBS
  174             021706    DEF          4.00     9,382.04    2527 0062
  250             021706    DEF          3.00        15.96    9953 0062 0883 001
  300             021706    DEF          5.00       355.28    9953 0018
  301             021706    DEF         11.00       361.54    9953 0018
  302             021706    DEF          3.00        81.42    9953 0018
  306             021706    DEF          1.00        16.42    9953 0018


MEMBER NAME: JANE DOE                          MEMBER NO.: 9999999999
 9999999999999   MCD 9999             021706 022106   4    021706       10,802.46        0.00          0.00
  99999999

HEADER EOBS:  2198 0016

REV CD HCPCS/RATE SRV DATE LVL CARE    UNITS     BILLED AMT   DETAIL EOBS
  111             021706    DEF          3.00     1,805.40
  112             021706    DEF          1.00       601.80
  250             021706    DEF        232.00       608.33
  258             021706    DEF         27.00       122.17
  272             021706    DEF          1.00       206.78
  300             021706    DEF          6.00       374.96
  301             021706    DEF         29.00       909.72
  307             021706    DEF          2.00        50.45
  312             021706    DEF          3.00       582.99
  370             021706    DEF          1.00       663.54
  460             021706    DEF          1.00        15.06
  720             021706    DEF          3.00     4,549.14
  732             021706    DEF          1.00       312.12


                   TOTAL UB CLAIMS DENIED:                 21,015.12      200.00          0.00
```

11.5 Denied Claims Page

FIELD	DESCRIPTION
PATIENT ACCOUNT	The 14-digit alpha/numeric Patient Control Number from Form Locator 3.
MEMBER NAME	The Member's last name and first initial.
MEMBER NUMBER	The Member's ten-digit Identification number as it appears on the Member's Identification card.
ICN	The 12-digit unique system generated identification number assigned to each claim by HP Enterprise Services.
ATTENDING PROVIDER	The member's attending provider.
CLAIM SERVICE DATE FROM – THRU	The date or dates the service was provided in month, day, and year numeric format.
DAYS	The number of days billed.
ADMIT DATE	The admit date of the member.
BILLED AMOUNT	The usual and customary charge for services provided for the Member.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
SPENDDOWN AMOUNT	The amount owed from the member.
CLAIM PMT. AMT.	The total dollar amount reimbursed by Medicaid for the claim listed.
EOB	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
CLAIMS DENIED ON THIS RA	The total number of denied claims on the Remittance Advice.
TOTAL BILLED	The total dollar amount billed by the Home Health Services for all claims listed on the DENIED CLAIMS page of the Remittance Advice (only on final page of section).
TOTAL PAID	The total dollar amount paid by Medicaid for all claims listed on the DENIED CLAIMS page of the Remittance Advice (only on final page of section).

```
REPORT:   CRA-IPSU-R                    COMMONWEALTH OF KENTUCKY (M1)                          DATE: 01/25/2007
RA#:      9999999                     MEDICAID MANAGEMENT INFORMATION SYSTEM                   PAGE:      17
                                            PROVIDER REMITTANCE ADVICE
                                              UB CLAIMS IN PROCESS


PROVIDER                                                               PAYEE ID              99999999
5555 ANY STREET                                                        NPI ID                99999999
SUITE 555                                                              CHECK/EFT NUMBER      999999999
CITY, KY 55555-0000                                                    ISSUE DATE            01/26/2007



  --ICN--            ATTENDING      SERVICE DATES   DAYS   ADMIT        BILLED      TPL        SPENDDOWN
 PATIENT ACCT. NUM.    PROV.        FROM    THRU            DATE        AMOUNT      AMOUNT     AMOUNT


MEMBER NAME: JOHN DOE                    MEMBER NO.: MBRID99999
ICN9999999999   NPI9999999     062206 062406    2    062206         4,010.60        0.00         0.00
PATACCT9999


REV CD HCPCS/RATE SRV DATE LVL CARE    UNITS      BILLED AMT  DETAIL EOBS
 111             062206    DEF          2.00      1,203.60
 250             062206    DEF         42.00        587.84
 258             062206    DEF         22.00        455.82
 272             062206    DEF          1.00          9.01
 370             062206    DEF          1.00        774.12
 410             062206    DEF          6.00        387.76
 710             062206    DEF          1.00        592.45

            TOTAL UB CLAIMS IN PROCESS:                             4010.60         0.00         0.00
```

11.6 Claims In Process Page

FIELD	DESCRIPTION
PATIENT ACCOUNT	The 14-digit alpha/numeric Patient Control Number from Form Locator 3.
MEMBER NAME	The Member's last name and first initial.
MEMBER NUMBER	The Member's ten-digit Identification number as it appears on the Member's Identification card.
ICN	The 13-digit unique system-generated identification number assigned to each claim by HP Enterprise Services.
ATTENDING PROVIDER	The attending provider's NPI.
CLAIM SERVICE DATE FROM – THRU	The date or dates the service was provided in month, day, and year numeric format.
DAYS	The number of days billed.
ADMIT DATE	The admit date of member.
BILLED AMOUNT	The usual and customary charge for services provided for the Member.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
SPENDDOWN AMOUNT	The amount owed from the member.

```
REPORT:   CRA-IPPD-R                         COMMONWEALTH OF KENTUCKY (M1)                          DATE:  01/30/2007
   RA#:      9999999                    MEDICAID MANAGEMENT INFORMATION SYSTEM                      PAGE:         2
                                              PROVIDER REMITTANCE ADVICE
                                               UB CLAIMS RETURNED


PROVIDER                                                                          PAYEE ID              99999999
5555 ANY STREET                                                                   NPI ID
CITY, KY 55555-5555                                                               CHECK/EFT NUMBER     999999999
                                                                                  ISSUE DATE           02/02/2007


  --ICN--           REASON CODE
9999999999999          01




  CLAIMS RETURNED:  01
```

11.7 Returned Claim

FIELD	DESCRIPTION
ICN	The 13-digit unique system generated identification number assigned to each claim by HP Enterprise Services.
REASON CODE	A code denoting the reason for returning the claim.
CLAIMS RETURNED ON THIS RA	The total number of returned claims on the Remittance Advice.

Note: Claims appearing on the "returned claim" page are forthcoming in the mail. The actual claim is returned with a "return to provider" sheet attached, indicating the reason for the claim being returned.

```
REPORT:   CRA-HHAD-R                          COMMONWEALTH OF KENTUCKY (M1)                          DATE:  01/23/2007
   RA#:      9999999                       MEDICAID MANAGEMENT INFORMATION SYSTEM                    PAGE:        33
                                               PROVIDER REMITTANCE ADVICE
                                                 UB CLAIM ADJUSTMENTS


PROVIDER                                                                           PAYEE ID            99999999
55555 ANY STREET                                                                   NPI ID
CITY, KY 55555-0000



     --ICN--      ATTEND PROV.          SERVICE DATES       BILLED       ALLOWED        TPL       CO-PAY   SPENDDOWN        PAID
     --PATIENT NUMBER--                 FROM    THRU        AMOUNT        AMOUNT        AMOUNT     AMOUNT    AMOUNT         AMOUNT

MEMBER NAME: JOHN DOE                    MEMBER NO.: 9999999999
  9999999999999  MCD 9999              030106 033106    (3,886.47)       (0.00)       (0.00)     (0.00)    (0.00)      (3,592.90)
     99999999999999


  9999999999999  MCD 9999              030106 033106     3,886.47         0.00         0.00       0.00      0.00           0.00
     99999999999999


HEADER EOBS:   0053 00A1



REV CD HCPCS/RATE SRV DATE   MODIFIERS      UNITS    BILLED AMT   ALLOWED AMT   DETAIL EOBS
 651              030106                    31.00     3,886.47         0.00     0686 0119
                                                                   NET OVERPAYMENT (AR)                               3,592.90


TOTAL NO. OF ADJ:       1
    TOTAL UB ADJUSTMENT CLAIMS:                              0.00                   0.00                   0.00
                                                                       0.00                   0.00               -3,592.90
```

Providers have an option of requesting an adjustment, as indicated above; or requesting a cash refund (form and instructions for completion can be found in the Billing Instructions).
If a cash refund is submitted, an adjustment **CANNOT** be filed.
If an adjustment is submitted, a cash refund **CANNOT** be filed.

11.8 Adjusted Claims Page

The information on this page reads left to right and does not follow the general headings.

FIELD	DESCRIPTION
PATIENT ACCOUNT	The 14-digit alpha/numeric Patient Control Number from Form Locator 3.
MEMBER NAME	The Member's last name and first initial.
MEMBER NUMBER	The Member's ten-digit Identification number as it appears on the Member's Identification card.
ICN	The 12-digit unique system generated identification number assigned to each claim by HP Enterprise Services.
CLAIM SERVICE DATES FROM – THRU	The date or dates the service was provided in month, day, and year numeric format.
BILLED AMOUNT	The usual and customary charge for services provided for the Member.
ALLOWED AMOUNT	The amount allowed for this service.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
COPAY AMOUNT	Copay amount to be collected from member.
SPENDDOWN AMOUNT	The amount to be collected from the member.
PAID AMOUNT	The total dollar amount reimbursed by Medicaid for the claim listed.
EOB	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
PAID AMOUNT	Amount paid.

Note: The ORIGINAL claim information appears first, followed by the NEW (adjusted) claim information.

```
REPORT:   CRA-TRAN-R                    COMMONWEALTH OF KENTUCKY                        DATE: 12/26/2006
RA#:      9999999                  MEDICAID MANAGEMENT INFORMATION SYSTEM               PAGE:        2
                                       PROVIDER REMITTANCE ADVICE
                                         FINANCIAL TRANSACTIONS


PROVIDER              J                                                       PAYEE ID          99999999
PO BOX 5555                                                                   NPI ID            99999999
CITY, KY 55555-5555



            ---------------NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS---------------


   TRANSACTION                  PAYOUT    REASON  RENDERING           SVC DATE
     NUMBER       --CCN--      --AMOUNT--  CODE   PROVIDER          FROM   THRU    MEMBER NO.   MEMBER NAME


                         NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS


            ---------------NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS-------------


                 REFUND       REASON
     --CCN--    --AMOUNT--     CODE     MEMBER NO.   MEMBER NAME


                        NO NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS


            ----------------ACCOUNTS RECEIVABLE----------------


      A/R         SETUP    RECOUPED     ORIGINAL      TOTAL              REASON
   NUMBER/ICN     DATE    THIS CYCLE    AMOUNT      -RECOUPED-   --BALANCE--  CODE


   1106         011306         0.00        22.41        0.00       22.41   92


            TOTAL BALANCE                                          22.41
```

11.9 Financial Transaction Page

11.9.1 Non-Claim Specific Payouts To Providers

FIELD	DESCRIPTION
TRANSACTION NUMBER	The tracking number assigned to each financial transaction.
CCN	The cash control number assigned to refund checks for tracking purposes.
PAYMENT AMOUNT	The amount paid to the provider when the financial reason code indicates money is owed to the provider.
REASON CODE	Payment reason code.
RENDERING PROVIDER	Rendering provider of service.
SERVICE DATES	The From and Through dates of service.
MEMBER NUMBER	The KY Medicaid member identification number.
MEMBER NAME	The KY Medicaid member name.

11.9.2 Non-Claim Specific Refunds From Providers

FIELD	DESCRIPTION
CCN	The cash control tracking number assigned to refund checks for tracking purposes.
REFUND AMOUNT	The amount refunded by provider.
REASON CODE	The two byte reason code specifying the reason for the refund.
MEMBER NUMBER	The KY Medicaid member identification number.
MEMBER NAME	The KY Medicaid member name.

11.9.3 Accounts Receivable

FIELD	DESCRIPTION
A / R NUBMER / ICN	This is the 13-digit Internal Control Number used to identify records for one accounts receivable transaction.
SETUP DATE	The date entered on the accounts receivable transaction in the MM/DD/CCYY format. This date identifies the beginning of the accounts receivable event.
RECOUPED THIS CYCLE	The amount of money recouped on this financial cycle.
ORIGINAL AMOUNT	The original accounts receivable transaction amount owed by the provider.
TOTAL RECOUPED	This amount is the total of the providers checks and recoupment amounts posted to this accounts receivable transaction.
BALANCE	The system generated balance remaining on the accounts receivable transaction.
REASON CODE	A two-byte alpha/numeric code specifying the reason an accounts receivable was processed against a providers account.

ANY RECOUPMENT ACTIVITY OR PAYMENTS RECEIVED FROM THE PROVIDER list below the "RECOUPMENT PAYMENT SCHEDULE." All initial accounts receivable allow 60 days from the "setup date" to make payment on the accounts receivable. After 60 days, if the accounts receivable has not been satisfied nor a payment plan initiated, monies are recouped from the provider on each Remittance Advice until satisfied.

This is your only notification of an accounts receivable setup. Please keep all Accounts Receivable Summary pages until all monies have been satisfied.

```
REPORT:   CRA-SUMM-R                    COMMONWEALTH OF KENTUCKY (M1)              DATE: 02/01/2007
  RA#:      9999999              MEDICAID MANAGEMENT INFORMATION SYSTEM            PAGE:       13
                                       PROVIDER REMITTANCE ADVICE
                                              SUMMARY


PROVIDER                                                            PAYEE ID                99999999
                                                                    NPI ID
P O BOX 555                                                         CHECK/EFT NUMBER       999999999
CITY, KY 55555-0000                                                 ISSUE DATE             02/02/2007

                          ------------------------CLAIMS DATA--------------------------

                           CURRENT       CURRENT   MONTH-TD       MONTH-TD    YEAR-TD         YEAR-TD
                           NUMBER        AMOUNT     NUMBER          AMOUNT    NUMBER           AMOUNT
             CLAIMS PAID        43    130,784.46        43       130,784.46    1,988     4,143,010.13
             CLAIM ADJUSTMENTS   0          0.00         0             0.00       18             0.00
             MASS ADJUSTMENTS    0          0.00         0             0.00        0             0.00
                TOTAL CLAIMS PAYMENTS 43 130,784.46      43       130,784.46    2,006     4,143,010.13
             CLAIMS DENIED        1                      1                       917
             CLAIMS IN PROCESS    2


                          ----------------------EARNINGS DATA----------------------
             PAYMENTS:
                CLAIMS PAYMENTS                   130,784.46         130,784.46           4,143,010.13

                SYSTEM PAYOUTS (NON-CLAIM SPECIFIC)     0.00               0.00                   0.00
                ACCOUNTS RECEIVABLE (OFFSETS):
                   CLAIM SPECIFIC:
                      CURRENT CYCLE                    (0.00)             (0.00)                 (0.00)
                      OUTSTANDING FROM PREVIOUS CYCLES (0.00)             (0.00)            (44,474.35)
                   NON-CLAIM SPECIFIC OFFSETS          (0.00)             (0.00)                 (0.00)

                NET PAYMENT                        130,784.46         130,784.46           4,098,535.78

             REFUNDS:
                CLAIM SPECIFIC ADJUSTMENT REFUNDS     (0.00)             (0.00)                 (0.00)
                NON-CLAIM SPECIFIC REFUNDS            (0.00)             (0.00)                 (0.00)

             OTHER FINANCIAL:
                MANUAL PAYOUTS (NON-CLAIM SPECIFIC)     0.00               0.00                   0.00
                VOIDS                                  (0.00)             (0.00)                 (0.00)

             NET EARNINGS                        130,784.46         130,784.46           4,098,535.78
```

```
REPORT:   CRA-EOBM-R                   COMMONWEALTH OF KENTUCKY (M1)                    DATE: 02/01/2007
   RA#:      9999999             MEDICAID MANAGEMENT INFORMATION SYSTEM             PAGE:        14
                                      PROVIDER REMITTANCE ADVICE
                                        EOB CODE DESCRIPTIONS


PROVIDER                                                          PAYEE ID              99999999
                                                                 NPI ID
P O BOX 555                                                      CHECK/EFT NUMBER       999999999
CITY, KY 55555-0000                                             ISSUE DATE            02/02/2007


   EOB CODE                      EOB CODE DESCRIPTION
   0022        COVERED DAYS ARE NOT EQUAL TO ACCOMMODATION UNITS.
   0271        CLAIM DENIED. MEMBER AVAILABLE INCOME INFORMATION NOT ON FILE FOR THE MONTH OF SERVICE.  PLEASE
               CONTACT DMS AT 502-564-6885.
   0409        INVALID PROVIDER TYPE BILLED ON CLAIM FORM.
   0883        CLAIM DENIED. DEPLICATE PROCEDURE HAS BEEN PAID.
   9999        PROCESSED PER MEDICAID POLICY


   HIPAA REASON CODE          HIPAA ADJ REASON CODE DESCRIPTION
   0016        Claim/service lacks information which is needed for adjudication. Additional information is supplied
               using remittance advice remarks codes whenever appropriate
   0018        Duplicate claim/service.
   0052        The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the
               service billed.
   0092        Claim Paid in full.
   00A1        Claim denied charges.
```

11.10 Summary Page

FIELD	DESCRIPTION
CLAIMS PAID	The number of paid claims processed, current month and year to date.
CLAIM ADJUSTMENTS	The number of adjusted/credited claims processed, adjusted/credited amount billed, and adjusted/credited amount paid or recouped by Medicaid. If money is recouped, the dollar amount is followed by a negative (-) sign. These figures correspond with the summary of the last page of the ADJUSTED CLAIMS section.
PAID MASS ADJ CLAIMS	The number of mass adjusted/credited claims, mass adjusted/credited amount billed, and mass adjusted/credited amount paid or recouped by Medicaid. These figures correspond with the summary line of the last page of the MASS ADJUSTED CLAIMS section. Mass Adjustments are initiated by Medicaid and HP Enterprise Services for issues that affect a large number of claims or providers. These adjustments have their own section "MASS ADJUSTED CLAIMS" page, but are formatted the same as the ADJUSTED CLAIMS page.
CLAIMS DENIED	These figures correspond with the summary line of the last page of the DENIED CLAIMS section.
CLAIMS IN PROCESS	The number of claims processed that suspended along with the amount billed of the suspended claims. These figures correspond with the summary line of the last page of the CLAIMS IN PROCESS section.

11.10.1   Payments

FIELD	DESCRIPTION
CLAIMS PAYMENT	The number of claims paid.
SYSTEM PAYOUTS	Any money owed to providers.
NET PAYMENT	Net payment amount.
REFUNDS	Any money refunded to Medicaid by a provider.
OTHER FINANCIAL	
NET EARNINGS	Total check amount.

EXPLANATION OF BENEFITS

FIELD	DESCRIPTION
EOB	A five-digit number denoting the EXPLANATION OF BENEFITS detailed on the Remittance Advice.
EOB CODE DESCRIPTION	Description of the EOB Code. All EOB Codes detailed on the Remittance Advice are listed with a description/ definition.
COUNT	Total number of times an EOB Code is detailed on the Remittance Advice.

EXPLANATION OF REMARKS

FIELD	DESCRIPTION
REMARK	A five-digit number denoting the remark identified on the Remittance Advice.
REMARK CODE DESCRIPTION	Description of the Remark Code. All remark codes detailed on the Remittance Advice are listed with a description/definition.
COUNT	Total number of times a Remark Code is detailed on the Remittance Advice.

EXPLANATION OF ADJUSTMENT CODE

FIELD	DESCRIPTION
ADJUSTMENT CODE	A two-digit number denoting the reason for returning the claim.
ADJUSTMENT CODE DESCRIPTION	Description of the adjustment Code. All adjustment codes detailed on the Remittance Advice are listed with a description/definition.
COUNT	Total number of times an adjustment Code is detailed on the Remittance Advice.

EXPLANATION OF RTP CODES

FIELD	DESCRIPTION
RTP CODE	A two-digit number denoting the reason for returning the claim.
RETURN CODE DESCRIPTION	Description of the RTP Code. All RTP codes detailed on the Remittance Advice are listed with a description/ definition.
COUNT	Total number of times an RTP Code is detailed on the Remittance Advice.

12 Appendix D

12.1 Remittance Advice Location Codes (LOC CD)

The following is a code indicating the Department for Medicaid Services branch/division or other agency that originated the Accounts Receivable:

A   Active

B   Hold Recoup - Payment Plan Under Consideration

C   Hold Recoup - Other

D   Other-Inactive-FFP-Not Reclaimed

E   Other – Inactive - FFP

F   Paid in Full

H   Payout on Hold

I   Involves Interest – Cannot Be Recouped

J   Hold Recoup Refund

K   Inactive-Charge off – FFP Not Reclaimed

P   Payout – Complete

Q   Payout – Set Up In Error

S   Active - Prov End Dated

T   Active Provider A/R Transfer

U   HP Enterprise Services On Hold

W   Hold Recoup - Further Review

X   Hold Recoup - Bankruptcy

Y   Hold Recoup - Appeal

Z   Hold Recoup - Resolution Hearing

13 Appendix E

13.1 Remittance Advice Reason Code (ADJ RSN CD or RSN CD)

The following is a two-byte alpha/numeric code specifying the reason an accounts receivable was processed against a provider's account:

01	Prov Refund – Health Insur Paid	32	Payout – Advance to be Recouped
02	Prov Refund – Member/Rel Paid	33	Payout – Error on Refund
03	Prov Refund – Casualty Insu Paid	34	Payout – RTP
04	Prov Refund – Paid Wrong Vender	35	Payout – Cost Settlement
05	Prov Refund – Apply to Acct Recv	36	Payout – Other
06	Prov Refund – Processing Error	37	Payout – Medicare Paid TPL
07	Prov Refund-Billing Error	38	Recoupment – Medicare Paid TPL
08	Prov Refund – Fraud	39	Recoupment – DEDCO
09	Prov Refund – Abuse	40	Provider Refund – Other TLP Rsn
10	Prov Refund – Duplicate Payment	41	Acct Recv – Patient Assessment
11	Prov Refund – Cost Settlement	42	Acct Recv – Orthodontic Fee
12	Prov Refund – Other/Unknown	43	Acct Receivable – KENPAC
13	Acct Receivable – Fraud	44	Acct Recv – Other DMS Branch
14	Acct Receivable – Abuse	45	Acct Receivable – Other
15	Acct Receivable – TPL	46	Acct Receivable – CDR-HOSP-Audit
16	Acct Recv – Cost Settlement	47	Act Rec – Demand Paymt Updt 1099
17	Acct Receivable – HP Enterprise Services Request	48	Act Rec – Demand Paymt No 1099
		49	PCG
18	Recoupment – Warrant Refund	50	Recoupment – Cold Check
19	Act Receivable-SURS Other	51	Recoupment – Program Integrity Post Payment Review Contractor A
20	Acct Receivable – Dup Payt	52	Recoupment – Program Integrity Post Payment Review Contractor B
21	Recoupment – Fraud		
22	Civil Money Penalty	53	Claim Credit Balance
23	Recoupment – Health Insur TPL	54	Recoupment – Other St Branch
24	Recoupment – Casualty Insur TPL	55	Recoupment – Other
25	Recoupment – Member Paid TPL	56	Recoupment – TPL Contractor
26	Recoupment – Processing Error	57	Acct Recv – Advance Payment
27	Recoupment – Billing Error	58	Recoupment – Advance Payment
28	Recoupment – Cost Settlement	59	Non Claim Related Overage
29	Recoupment – Duplicate Payment	60	Provider Initiated Adjustment
30	Recoupment – Paid Wrong Vendor	61	Provider Initiated CLM Credit
31	Recoupment – SURS		

62	CLM CR-Paid Medicaid VS Xover	95	Beginning Recoupment Balance
63	CLM CR-Paid Xover VS Medicaid	96	Ending Recoupment Balance
64	CLM CR-Paid Inpatient VS Outp	97	Begin Dummy Rec Bal
65	CLM CR-Paid Outpatient VS Inp	98	End Dummy Recoup Balance
66	CLS Credit-Prov Number Changed	99	Drug Unit Dose Adjustment
67	TPL CLM Not Found on History	AA	PCG 2 Part A Recoveries
68	FIN CLM Not Found on History	BB	PCG 2 Part B Recoveries
69	Payout-Withhold Release	CB	PCG 2 AR CDR Hosp
71	Withhold-Encounter Data Unacceptable	DG	DRG Retro Review
72	Overage .99 or Less	DR	Deceased Member Recoupment
73	No Medicaid/Partnership Enrollment	IP	Impact Plus
74	Withhold-Provider Data Unacceptable	IR	Interest Payment
75	Withhold-PCP Data Unacceptable	CC	Converted Claim Credit Balance
76	Withhold-Other	MS	Prog Intre Post Pay Rev Cont C
77	A/R Member IPV	OR	On Demand Recoupment Refund
78	CAP Adjustment-Other	RP	Recoupment Payout
79	Member Not Eligible for DOS	RR	Recoupment Refund
80	Adhoc Adjustment Request	SS	State Share Only
81	Adj Due to System Corrections	UA	HP Enterprise Services Medicare Part A Recoup
82	Converted Adjustment	XO	Reg. Psych. Crossover Refund
83	Mass Adj Warr Refund		
84	DMS Mass Adj Request		
85	Mass Adj SURS Request		
86	Third Party Paid – TPL		
87	Claim Adjustment – TPL		
88	Beginning Dummy Recoupment Bal		
89	Ending Dummy Recoupment Bal		
90	Retro Rate Mass Adj		
91	Beginning Credit Balance		
92	Ending Credit Balance		
93	Beginning Dummy Credit Balance		
94	Ending Dummy Credit Balance		

14 Appendix F

14.1 Remittance Advice Status Code (ST CD)

The following is a one-character code indicating the status of the accounts receivable transaction:

A   Active

B   Hold Recoup - Payment Plan Under Consideration

C   Hold Recoup - Other

D   Other-Inactive-FFP-Not Reclaimed

E   Other – Inactive - FFP

F   Paid in Full

H   Payout on Hold

I   Involves Interest – Cannot Be Recouped

J   Hold Recoup Refund

K   Inactive-Charge off – FFP Not Reclaimed

P   Payout – Complete

Q   Payout – Set Up In Error

S   Active - Prov End Dated

T   Active Provider A/R Transfer

U   HP Enterprise Services On Hold

W   Hold Recoup - Further Review

X   Hold Recoup - Bankruptcy

Y   Hold Recoup - Appeal

Z   Hold Recoup - Resolution Hearing